Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Brian L Wilson D.D.S.

Respondent Name
Texas A & M University System

MFDR Tracking Number
M4-13-0876-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
December 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 11/5/12 our office received a check from Workman's Compensation for a total of $3168.00. Upon receipt of this check Ms. Shannon's office was contacted and questioned regarding the percentage of reimbursement, which appears to be a different percentage from previous payment and greatly reduced. Ms. Shannon's office stated the bridge was paid at the State Medicaid Level of Reimbursement. This appears to be a different percentage from previous claims which were paid at Reasonable and Customary. Our Office is not a Medicaid provider."

Amount in Dispute: $2,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement has been made at the TDI-DWC dental fee schedule as outlined in rule 134.303."

Response Submitted by: Starr Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2012	DS 6752, DS 6242	$2,500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.303 sets out the reimbursement guidelines for dental services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W3 – Additional reimbursement made on reconsideration

Issues

1. What is the applicable rule that relates to reimbursement of disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.303(c) To determine the maximum allowable reimbursements (MARs), the following apply; (1) The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%." Calculations of Maximum Allowable Reimbursement (MAR) will be as follows;

Date of Service	Submitted Code	Submitted Charge	MAR Texas Medicaid Dental Fee Schedule Amount x 200%
May 10, 2012	D6752	$951.00	$258.72 X 200% = $517.44
May 10, 2012	D6752	$951.00	$258. 72 X 200% = $517.44
May 10, 2012	D6242	$932.00	$258.72 X 200% = $517.44
May 10, 2012	D6242	$932.00	$258.72 X 200% = $517.44
May 10, 2012	D6752	$951.00	$258.72 X 200% = $517.44
May 10, 2012	D6752	$951.00	$258.72 X 200% = $517.44
	Total	$5,668.00	$3,104.64

2. The MAR for the services in dispute is $3,104.64 the carrier paid $3,168.00. No additional payment can be recommended. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 18, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.